Washington State
DEPARTMENT OF
SOCIAL & HEALTH
SERVICES

Medical Assistance Administration

Vision Care

Billing Instructions
WAC 388-544-0010 through WAC 388-544-0600

July 2005

About this publication

This publication supersedes all previous MAA Vision Care Billing Instructions and Numbered Memoranda **03-66 MAA** and **04-46 MAA**.

MAA encourages Ophthalmologists to also refer to the current version of the *Physicians-Related Services (RBRVS) Billing Instructions* for further billing codes.

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Where can I find copies of other billing instructions?

To obtain MAA's provider numbered memoranda and billing instructions, go to MAA's website at http://maa.dshs.wa.gov (click on the *Billing Instructions/Numbered Memoranda* link).

To request a free paper copy from the Department of Printing:

Go to: http://www.prt.wa.gov/ (Orders filled daily).

1. Click **General Store**.

2. If a **Security Alert** screen is displayed, click **OK.**

a. Select either **I'm New** or **Been Here.**
i. If new, fill out the registration and click **Register**.
ii. If returning, type your email and password, then click **Login**.

3. At the **Store Lobby** screen, click **Shop by Agency**. Select **Department of Social and Health Services**, then select **Medical Assistance.**

4. Select **Billing Instructions, Forms, Healthy Options, Numbered Memo, Publications** or **Issuance Correction**. You will then need to select a year and the select the item by number and title.

Fax/Call: Dept. of Printing/Attn: Fulfillment at FAX (360) 586-6361/telephone (360) 586-6360. (Orders may take up to 2 weeks to fill.)

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Section H: How to Complete the HCFA-1500 Claim Form

Important Contacts

A provider may use MAA's toll-free lines for questions regarding its program. However, MAA's response is based solely on the information provided to MAA's representative at the time of inquiry, and in no way exempts a provider from following the laws and rules that govern MAA's programs. [WAC 388-502-0020 (2)].

How do I obtain information on becoming a DSHS provider, submitting a change of address or ownership, or to ask questions about the status of a provider application?

Provider Enrollment Unit
http://maa.dshs.wa.gov/provrel
Phone: (866) 545-0544 (toll free)

Where do I send my claims?

Internet Billing (Electronic Claims Submission):

EDI Gateway
http://www.acs-gcro.com/
Select *Medicaid*, then *Washington State*

All other HIPAA transactions
https://wamedweb.acs-inc.com/

To use HIPAA Transactions and/or EDI Gateway, enroll with ACS EDI Gateway Phone: (800) 833-2051 (toll free).

Hard Copy Claims:

Division of Program Support
PO Box 9248
Olympia WA 98507-9248

How do I obtain copies of MAA's billing instructions or numbered memoranda?

To **view and download,** visit MAA on the web:
http://maa.dshs.wa.gov/ Click on *Billing Instructions/ Numbered Memoranda*

To **have a paper copy sent to you,** visit the Dept. of Printing on the web:
http://www.prt.wa.gov/ Click on *General Store*

How do I obtain DSHS forms?

To **view and download** DSHS forms, visit DSHS Forms and Records Management Service on the web:
http://www1.dshs.wa.gov/msa/forms/eforms.html

To **have a paper copy sent** to you, contact DSHS Forms and Records Management Service:
Phone: (360) 664-6047
Fax: (360) 664-6186

Include in your request:

- Form number and name;
- Quantity you want;
- Your name;
- Your office/organization name; and
- Your complete mailing address.

Where do I order hardware?

Order hardware from MAA's contractor:

Airway Optical
11919 West Sprague Avenue
PO Box 1959
Airway Heights, WA 99001-1959
Customer Service Phone (toll free)
(888) 606-7788
Fax: (toll free) (888) 606-7789

Who do I contact if I have a client who needs low vision aids?

Community Services for the Blind and Partially Sighted (Seattle)
Phone: (800) 458-4888 (toll free)

Lilac Blind Foundation (Spokane)
Phone: (800) 422-7893 (toll free)

Where do I call if I have questions regarding policy, payments, denials, or general questions regarding claims processing, or MAA Managed Care?

Provider Relations Unit
http://maa.dshs.wa.gov/provrel
Phone: (800) 562-6188 (toll free)

Where do I call or write if I have questions regarding...

Private insurance or third-party liability, other than MAA Managed Care?

Coordination of Benefits Section
(800) 562-6136 (toll free)

Limitation Extension?

Division of Medical Management
Limitation Extension
PO Box 45506
Olympia, WA 98504-5506
Fax: (360) 586-1471

Electronic billing?

Electronic Media Claims Help Desk
(360) 725-1267

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Definitions

This section defines terms and acronyms used in this booklet.

Authorization - MAA official approval for action taken for, or on behalf of, an eligible Medical Assistance client. This approval is only valid if the client is eligible on the date of service.

Authorization number - A 9-digit number assigned by MAA that identifies individual requests for services or equipment. The same authorization number is used throughout the history of the request, whether it is approved, pended, or denied.

Blindness - A diagnosis of visual acuity for distance vision of 20/200 or worse in the better eye with best correction or a limitation of the client's visual field (widest diameter) subtending an angle of less than 20 degrees from central. [WAC 388-544-0050]

Client - An applicant for, or recipient of, DSHS medical care programs.

Conventional soft contact lenses and **rigid gas permeable contact lenses** - Federal Drug Administration (FDA)-approved contact lenses that do not have a scheduled replacement (discard and replace with new contacts) plan. The soft lenses usually last one year, and the rigid gas permeable lenses usually last two years. Although some of these lenses are designed for extended wear, MAA generally approves only those lenses that are designed to be worn as daily wear (remove at night). [WAC 388-544-0050]

Department - The state Department of Social and Health Services (DSHS). [WAC 388-500-0005]

Disposable contact lenses - FDA-approved contact lenses that have a planned replacement schedule (e.g., daily, every two weeks, monthly, quarterly). The contacts are then discarded and replaced with new ones as scheduled. Although many of these lenses are designed for extended wear, MAA generally approves only those lenses that are designed to be worn as daily wear (remove at night). [WAC 388-544-0050]

Expedited prior authorization (EPA) - For the purposes of the vision program EPA is the process designed by MAA to eliminate the need to obtain prior authorization (see definition for "prior authorization"). MAA establishes authorization criteria and identifies these criteria with specific codes. If the provider determines the client meets the criteria, the provider creates the authorization number using the specific MAA-established codes.

Expedited prior authorization number - A 9-digit number created by the provider to bill MAA for diagnoses, procedures, and services that meet MAA's EPA criteria.

- The first 6 digits of the EPA number must be **870000**;
- The last 3 digits must be the code number of the diagnostic condition, procedure, or service that meets the EPA criteria.

Explanation of Benefits (EOB) - A coded message on the Medical Assistance Remittance and Status Report that gives detailed information about the claim associated with that report.

Explanation of Medicare Benefits (EOMB) - A federal report generated for Medicare providers displaying transaction information regarding Medicare claims processing and payments.

Extended wear soft contacts - Contact lenses that are designed to be worn for longer periods than daily wear (remove at night) lenses. These can be conventional soft or disposable lenses designed to be worn for several days and nights before removal. MAA's opinion is that the prolonged use of overnight wear may increase the risk of corneal swelling and ulceration. Therefore, MAA approves their use in limited situations where they are used as a therapeutic contact bandage lens or for aphakic clients. [WAC 388-544-0050]

Hardware - Eyeglass frames and lenses and contact lenses. [WAC 388-544-0050]

ICD-9 CM Diagnosis Codes – Classifies morbidity and mortality information for statistical purposes, indexing of hospital records by disease and operations, data storage, and retrieval. The disease classification has been expanded to include health-related conditions and to provide great specificity at the fifth-digit level of detail. These fifth digits are not optional; they are intended for use in recording the information substantiated in the clinical record.

Limitation extension - A process for requesting and approving reimbursement for covered services whose proposed quantity, frequency, or intensity exceeds that which MAA routinely reimburses. Limitation extensions require prior authorization.

Managed care - A comprehensive system of medical and health care delivery including preventive, primary, specialty, and ancillary health services. These services are provided either through a managed care organization (MCO) or primary care case manager (PCCM) provider. [WAC 388-538-050]

Maximum allowable fee - The maximum dollar amount that MAA reimburses a provider for specific services, supplies, and equipment.

Medicaid - The state and federally funded aid program that covers the Categorically Needy (CNP) and Medically Needy (MNP) programs.

Medical Assistance Administration (MAA) - The administration within DSHS authorized by the secretary to administer the acute care portion of the Title XIX Medicaid, Title XXI Children's Health Insurance Program (SCHIP), and the state-funded medical care programs, with the exception of certain non-medical services for persons with chronic disabilities.

Medical Identification (ID) card - The card issued to clients to confirm their eligibility for medical care. These cards are good only for the dates printed on them. Clients will receive a Medical ID card in the mail each month they are eligible. These cards are also known as DSHS Medical ID cards and were formerly called DSHS medical coupons or MAID cards.

Medically necessary - A term for describing requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the client that endanger life, or cause suffering or pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service. For the purpose of this section, "course of treatment" may include mere observation or, where appropriate, no treatment at all. [WAC 388-500-0005]

Medicare - The federal government health insurance program for certain aged clients or clients with disabilities under Titles II and XVIII of the Social Security Act. Medicare has two parts:

- "Part A" covers the Medicare inpatient hospital, post-hospital skilled nursing facility care, home health services, and hospice care.
- "Part B" is the supplementary medical insurance benefit (SMIB) covering the Medicare doctor's services, outpatient hospital care, outpatient physical therapy and speech pathology services, home health care, and other health services and supplies not covered under Part A of Medicare.
  [Refer to WAC 388-500-0005]

Patient Identification Code (PIC) - An alphanumeric code that is assigned to each Medical Assistance client consisting of:

- First and middle initials (or a dash (-) must be entered if the middle initial is not indicated).
- Six-digit birthdate, consisting of numerals only (MMDDYY).
- First five letters of the last name (and spaces if the name is fewer than five letters).
- Alpha or numeric character (tiebreaker).

Primary Care Case Management (PCCM) - The health care management activities of a provider that contracts with the department to provide primary health care services and to arrange and coordinate other preventive, specialty, and ancillary health services. [WAC 388-538-050]

Primary care provider (PCP) - A person licensed or certified under Title 18 RCW including, but not limited to, a physician and advanced registered nurse practitioner (ARNP), or a physician assistant (PA) who supervises, coordinates, and provides health services to a client or an enrollee, initiates referrals for specialist and ancillary care, and maintains the client's or enrollee's continuity of care.
[Refer to WAC 388-538-050]

Prior authorization - Written MAA approval for certain medical services, equipment, or supplies before the services are provided to clients, as a precondition for provider reimbursement. Expedited prior authorization and limitation extensions are forms of prior authorization.

Provider or provider of service - An institution, agency, or person:

- Who has a signed agreement [Core Provider Agreement] with the department to furnish medical care, goods, and/or services to clients; and
- Is eligible to receive payment from the department. [WAC 388-500-0005]

Remittance and Status Report (RA) - A report produced by MAA's claims processing system (known as the Medicaid Management Information System or MMIS) that provides detailed information concerning submitted claims and other financial transactions.

Specialty contact lens design - Custom contact lenses that have a more complex design than a standard spherical lens. These specialty contact lenses (e.g., lenticular, aspheric, or myodisc) are designed for the treatment of specific disease processes, such as keratoconus, or are required due to high refractive errors. This definition of specialty contact lens does not include lenses used for surgical implantation. [WAC 388-544-0050]

Stable visual condition - A client's eye condition has no acute disease or injury; or the client has reached a point after any acute disease or injury where the variation in need for refractive correction has diminished or steadied. The client's vision condition has stabilized to the extent that eyeglasses or contact lenses are appropriate and that any prescription for refractive correction is likely to be sufficient for one year or more. [WAC 388-544-0050]

Third party - Any entity that is or may be liable to pay all or part of the medical cost of care of a federal Medicaid or state medical program client. [WAC 388-500-0005]

Title XIX - The portion of the federal Social Security Act that authorizes grants to states for medical assistance programs. Title XIX is also called Medicaid. [WAC 388-500-0005]

Usual and customary fee - The rate that may be billed to the department for a certain service or equipment. This rate may not exceed:

1) The usual and customary charge billed to the general public for the same services; or
2) If the general public is not served, the rate normally offered to other contractors for the same services.

Visual field exam or testing - A process to determine defects in the field of vision and test the function of the retina, optic nerve and optic pathways. The process may include simple confrontation to increasingly complex studies with sophisticated equipment. [WAC 388-544-0050]

Washington Administrative Code (WAC) - Codified rules of the State of Washington.

About the Program

What is the purpose of the Vision Care Program?

The purpose of MAA's Vision Care Program is to provide the following medically necessary services and hardware to eligible MAA clients:

- Eye care services (eye examinations, refractions, etc.);
- Eyeglasses (frames and lenses);
- Contact lenses;
- Ocular prosthetics; and
- Eye surgery.

Provider Responsibility [WAC 388-544-0150 (1)]

Enrolled/contracted eye care providers must:

- Meet the requirements in Chapter 388-502 WAC;
- Provide only those services that are within the scope of the provider's license;
- Obtain all hardware and contact lenses for MAA clients from MAA's contracted supplier; and
- Return all unclaimed hardware and contact lenses to MAA's contracted supplier using a postage-paid envelope furnished by the contractor.

Note: Please check the accuracy of all prescriptions and order forms submitted to MAA's contracted provider.

Who is eligible to provide vision care services to MAA clients? [WAC 388-544-0150 (2)]

The following providers are eligible to enroll/contract with MAA to provide and bill for vision care services furnished to eligible clients:

- Ophthalmologists;
- Optometrists;
- Opticians; and
- Ocularists.

Client Eligibility

Who is eligible for vision care? [WAC 388-544-0100 (1)]

Clients with one of the following medical program identifiers on their DSHS Medical Identification cards are eligible for vision care:

Medical Program Identifier	Medical Program Description
CNP	Categorically Needy Program
CNP – CHIP	Categorically Needy Program – State Children's Health Insurance Program
LCP – MNP	Limited Casualty Program – Medically Needy Program
GA-U **No Out of State Care**	General Assistance-Unemployable – No Out of State Care (except in designated bordering cities)
General Assistance	ADATSA

Limited Coverage:

- MAA covers vision care under Emergency Medical Only program (may also be referred to as the Alien Emergency Medical (AEM) program **only** when the services are directly related to an emergency medical condition, and prior authorization is obtained.
- For Qualified Medicare Beneficiary clients, MAA pays only for Medicare premium co-pays, coinsurance, and deductibles.

No Coverage:

Clients with Family Planning Only and TAKE CHARGE medical program identifiers do **not** have vision care coverage.

MAA Managed Care Clients [Refer to WAC 388-544-0100 (2)]

Clients with an identifier in the HMO column on their DSHS Medical ID cards are enrolled in one of MAA's managed care plans and are covered for vision care services as follows:

- **Eye exams, refractions, and/or visual fields** must be requested and provided directly through the client's managed care plan. Clients can contact their plans by calling the telephone number listed on their Medical ID card;

- **Eyeglass frames, lenses, and contact lenses** must be ordered from MAA's contractor. These items are covered fee-for-service. (See Section E – *Where and How do I Order*?) Use the guidelines found in this billing instruction for clients enrolled in an MAA managed care plan.

Primary Care Case Management (PCCM) clients will have the PCCM identifier in the HMO column on their Medical ID cards. Please make sure these clients have been referred by their PCCM prior to receiving services. The referral number is required in field **17a** on the HCFA-1500 claim form. (See Section G - *General Billing* for further information.)

Note: For further information on MAA's managed care plans, see MAA's website: http://maa.dshs.wa.gov/HealthyOptions

Coverage – Examinations and Refractions

When does MAA cover eye examinations and refraction services? [Refer to WAC 388-544-0250 (1)]

MAA covers eye examinations and refraction services for asymptomatic clients as follows:

- For **adults** (clients 21 years of age or older): Once every 24 months;
- For **children** (clients 20 years of age or younger): Once every 12 months;
- For **clients with developmental disabilities** (regardless of age): Once every 12 months.

The provider must document the diagnosis and/or treatment in the client's record to justify the frequency of examinations and other services.

Exams/Refractions Due to Medical Conditions or Medication [Refer to WAC 388-544-0250 (2)]

MAA covers medically necessary nursing facility visits (procedure codes 99311 – 99313). There must be communication between the attending physician and the consulting specialist regarding the resident's specific needs. Group vision screenings are not covered (see page C.16 *Noncovered Services*).

MAA covers eye examinations and refraction services as often as medically necessary when:

- The provider is diagnosing or treating the client for a medical condition that has symptoms of vision problems or disease (e.g., glaucoma, conjunctivitis, corneal abrasion/laceration, etc.); or
- The client is on medication that affects vision.

Exams/Refractions Due to Lost or Broken Hardware

[Refer to WAC 388-544-0250 (3)]

MAA covers eye examinations/refractions outside the time limitations listed on page C.1 when the eye examination/refraction is necessary due to lost or broken eyeglasses/contacts. To receive payment:

- For **adults** (clients 21 years of age or older),), providers must follow the expedited prior authorization (EPA) process (see Section D – *Authorization* **EPA# 610**) and document the following in the client's file:

  ✓ The eyeglasses or contacts are lost or broken; and
  ✓ The last examination was at least 18 months ago;

- For **children** (clients 20 years of age or younger), MAA does **not** require prior authorization;

- For **clients with developmental disabilities** (regardless of age), MAA does **not** require prior authorization.

Visual Field Exams

[Refer to WAC 388-544-0250 (4)]

MAA covers visual field exams (e.g., CPT codes 92081, 92082, and 92083) for the diagnosis and treatment of abnormal signs, symptoms, or injuries.

Note: MAA does not reimburse for visual field exams that are done by simple confrontation. Use Medicare criteria for the billing of visual field services for MAA clients. Your records must support the medical necessity for the visual field tests.

To receive payment, providers must document all of the following in the client's record:

✓ The extent of the testing;
✓ Why the testing was reasonable and necessary for the client; and
✓ The medical basis for the frequency of testing.

Note: See page G.1 for information on billing eye exams, refractions, evaluation and management (E&M) codes, etc.

Coverage – Eyeglasses (Frames and/or Lenses) and Repair Services

When does MAA cover eyeglasses (frames and/or lenses)?

[Refer to WAC 388-544-0300 (1)]

MAA covers eyeglasses for asymptomatic clients as follows:

- For **adults** (clients 21 years of age or older): Once every 24 months;
- For **children** (clients 20 years of age or younger): Once every 12 months;
- For **clients with developmental disabilities** (regardless of age): Once every 12 months.

Clinical Criteria for Asymptomatic Clients

MAA covers eyeglasses for asymptomatic clients when the client meets the following clinical criteria:

- The client has a stable visual condition (see Definitions section – *stable visual condition*);
- The client's treatment is stabilized;
- The client's prescription is less than 18 months old; and
- One of the following minimum correction needs **in at least one eye** is documented in the client's file:
  - ✓ Sphere power equal to, or greater than, plus or minus 0.50 diopter;
  - ✓ Astigmatism power equal to, or greater than, plus or minus 0.50 diopter; or
  - ✓ The add power equal to or greater than 1.0 diopter for bifocals or trifocals.

Note: MAA limits eyeglass reimbursement to specific frames, lenses, and contact lenses as offered by the MAA contractor. MAA pays a fitting fee **only** for frames, lenses, and contact lenses provided by or obtained through MAA's contractor (see Section E: *Where and How Do I Order?*).

Accommodative Esotropia or Strabismus [WAC 388-544-0300 (2)]

MAA covers eyeglasses and/or lenses for clients who are 20 years of age or younger with a diagnosis of accommodative esotropia or any strabismus correction. In this situation, the client is not subject to the clinical criteria on page C.3.

Durable or Flexible Frames [WAC 388-544-0300 (3)]

MAA covers selected frames called "durable" or "flexible" frames through MAA's contracted supplier when the client has a diagnosed medical condition that has contributed to two or more broken eyeglass frames in a 12-month period. Providers must follow the expedited prior authorization process (see Section D – *Authorization* **EPA# 619, EPA# 620**).

Nonallergenic Frames [WAC 388-544-0300 (4)]

MAA covers the cost of coating contract eyeglass frames to make the frames nonallergenic if the client has a medically diagnosed and documented allergy to the materials in the available eyeglass frames.

Incidental Repairs [WAC 388-544-0300 (5)]

MAA pays for incidental repairs to a client's eyeglass frames when **all** of the following apply:

- The provider typically charges the general public for the repair or adjustment;
- The contractor's one year warranty period has expired; **and**
- The cost of the repair does not exceed MAA's cost for replacement frames.

Note: Incidental repairs are billable by ophthalmologists, optometrists, and opticians.

Eyeglass repair parts and materials may be ordered from the state contractor or any manufacturer of optical devices and will be paid up to MAA's maximum allowable fee for repair.

Use the following procedure code when billing MAA for an eyeglass repair. Include an invoice when you bill:

CPT Procedure Code	Description
92390	Materials for eyeglass repair (specify materials billed).

Note: Use CPT code 92390 for repairs only when materials are being replaced. Materials must be documented with an invoice or statement from the manufacturer or the contractor showing the client's name and date. If the needed materials are in stock and a charge is normally made to the public for these materials, the repair fee requirement would be satisfied providing that the use of the specific part is documented in the client's record.

Replacement Frames and/or Lenses [Refer to WAC 388-544-0300 (6)]

MAA covers replacement eyeglass frames and/or lenses that have been lost or broken. To receive payment:

- For **adults** (clients 21 years of age or older) providers must follow the expedited prior authorization process (see Section D – *Authorization* **EPA# 615, EPA# 618**);
- For **children** (clients 20 years of age or younger) MAA does **not** require prior authorization;
- For **clients with developmental disabilities** (regardless of age) MAA does **not** require prior authorization.

Back-up Eyeglasses [Refer to WAC 388-544-0300 (7)]

MAA covers one pair of back-up eyeglasses when contact lenses are medically necessary and the contact lenses are the client's primary visual correction aid (see Contact Lenses, page C.11). MAA limits back-up eyeglasses as follows:

- For **adults** (clients 21 years or older): Once every 6 years.
- For **children** (clients 20 years or younger): Once every 2 years.
- For **clients with developmental disabilities** (regardless of age): Once every 2 years.

Coverage – Plastic Eyeglass Lenses and Services

When does MAA cover eyeglass lenses and services?

[Refer to WAC 388-544-0350 (1)]

MAA covers the following plastic scratch-resistant eyeglass lenses:

- Single vision lenses;
- Round or flat top D-style bifocals;
- Flat top trifocals; and
- Slab-off and prism lenses (including Fresnel lenses).

Note: MAA's contractor supplies **all** plastic eyeglass lenses with a scratch-resistant coating.

Replacing Bifocal or Trifocal Eyeglass Lenses

[Refer to WAC 388-544-0350 (2)]

MAA allows bifocal eyeglass lenses to be replaced with trifocal or single vision lenses, or trifocal lenses to be replaced with bifocals or single vision lenses when all of the following apply:

- A client has attempted to adjust to the bifocals or trifocals for at least 60 days;
- The client is unable to make the adjustment; and
- The bifocal or trifocal lenses being replaced are returned to the provider.

High Index Eyeglass Lenses [Refer to WAC 388-544-0350 (3)]

MAA covers high index lenses for clients who require one of the following in at least one eye:

- A spherical refractive correction of plus or minus 8.0 diopters or greater; or
- A cylinder correction of plus or minus 3.0 diopters or greater.

To receive payment, providers must follow the expedited prior authorization process (see Section D- *Authorization* **EPA# 625**).

Tinting [Refer to WAC 388-544-0350 (4)]

MAA covers the tinting of plastic lenses through MAA's contracted lens supplier when the client's medical need is diagnosed and documented as one or more of the following chronic (expected to last longer than 3 months) eye conditions causing photophobia:

Medical Problems	ICD-9-CM Diagnosis Codes
Blindness	369.00 - 369.9
Chronic corneal keratitis	370.00 - 370.07
Chronic iritis, iridocyclitis (uveitis)	364.10 - 364.11 364.51 - 364.59
Diabetic retinopathy	362.01 - 362.02
Fixed pupil	379.42 - 379.49
Glare from cataracts	366.00 - 366.9
Macular degeneration	362.50 - 362.66
Migraine disorder	346.00 - 346.91
Ocular albinism	270.2
Optic atrophy and/or optic neuritis	377.10 - 377.63
Rare photo-induced epilepsy conditions	345.00 - 345.91
Retinitis pigmentosa	362.74

Photochromatic Eyeglass Lenses [Refer to WAC 388-544-0350 (5)]

MAA covers both *tinted* lenses and *photochromatic* lenses for appropriate medical conditions. *Tinted* lenses are colored lenses that remain the same color indoors and outdoors.

Photochromatic lenses are lenses that darken when they are exposed to sunlight (photochromatic lenses do not darken as well inside automobiles).

MAA covers photochromatic lenses when the client's medical need is diagnosed and documented as related to either of the following:

Medical Problems	ICD-9-CM Diagnosis Codes
Ocular Albinism	270.2
Retinitis pigmentosa	362.74

Polycarbonate Eyeglass Lenses [Refer to WAC 388-544-0350 (6)]

MAA covers polycarbonate lenses for clients with developmental disabilities.

MAA covers polycarbonate lenses for clients without developmental disabilities as follows:

Medical Problems	ICD-9-CM Diagnosis Codes
For clients who are blind in one eye and need protection for the other eye, regardless of whether a vision correction is required	369.60 - 369.69 369.70 - 369.76
For infants and toddlers with motor ataxia	331.89, 781.2 334.0 - 334.9, 781.3
For clients 20 years of age or younger who are diagnosed with strabismus	378.00 - 378.9
For clients 20 years of age or younger who are diagnosed with amblyopia	368.01 - 368.03

Requests for Eyeglass Lenses Only [Refer to WAC 388-544-0350 (7)]

MAA covers requests for lenses only (lenses without frames) for clients who own their own eyeglass frames not purchased by MAA when:

- The eyeglass frames are serviceable; and
- The size and style of the required lenses meet MAA's contract requirements. The lenses must be compatible with MAA's contracted frames.

> **Note:** Due to time, exposure to elements, and concealed damage, working with a client's frames can be unpredictable. MAA and MAA's contractor **do not** accept responsibility for these frames.

Replacements due to Lost or Broken Eyeglass Lenses

[Refer to WAC 388-544-0350 (8)(a)]

MAA covers replacement eyeglass lenses that have been lost or broken. To receive payment:

- For **adults** (clients 21 years of age or older) providers must follow the expedited prior authorization process (see Section D – *Authorization* **EPA# 623**);
- For **children** (clients 20 years of age or younger) MAA does not require prior authorization;
- For **clients with developmental disabilities** (regardless of age) MAA does not require prior authorization.

Replacements due to Refractive Changes

[WAC 388-544-0350 (8)(b) and (c)]

MAA covers eyeglass lens replacements due to refractive changes, without regard to time limits, when caused by one of the following:

- **Eye surgery**, the **effect(s) of prescribed medication**, or **one or more diseases affecting vision.** For each of these, all of the following must be documented in the client's file:

  ✓ The client has a stable visual condition (see Definitions section for a definition of *stable visual condition*);

  ✓ The client's treatment is stabilized;

  ✓ The lens correction must have a 1.0 or greater diopter change between the sphere or cylinder correction in at least one eye; **and**

  ✓ The previous and new refraction.

  To receive payment, providers must follow the expedited prior authorization process (see Section D – *Authorization* **EPA# 622**).

- **Headaches, blurred vision,** or **difficulty with school or work.** For each of these, all of the following must be documented in the client's file:

  ✓ Copy of the current prescription (the prescription is less than 18 months old);

  ✓ Date of last dispensing, if known;

  ✓ Absence of a medical condition that is known to cause temporary visual acuity changes (e.g., diabetes, pregnancy, etc.); **and**

  ✓ A refractive change of at least .75 diopter or greater between the sphere or cylinder correction in at least one eye.

  To receive payment, providers must follow the expedited prior authorization process (see Section D- *Authorization* **EPA# 624**).

Coverage – Contact Lenses and Services

What types of contact lenses and services does MAA cover?

[Refer to WAC 388-544-0400 (1) through (3)]

MAA covers the following types of contact lenses as the client's primary refractive correction method when a client has a spherical correction of plus or minus 6.0 diopters or greater in at least one eye. In order to qualify for the spherical correction, the prescription may be from either the glasses or the contact lenses prescriptions and/or written in either "minus cyl" or "plus cyl" form. (See below for exceptions to the plus or minus 6.0 diopter criteria):

1. **Conventional soft** or **rigid gas permeable** contact lenses that are prescribed for daily wear;

2. **Disposable** contact lenses that are prescribed for daily wear and have a monthly or quarterly planned replacement schedule, as follows:

   - 12 pairs of monthly replacement contact lenses; or
   - 4 pairs of 3-month replacement contact lenses.

Medical Problems	ICD-9-CM Diagnosis Code
Hypermetropia	367.0
Myopia	367.1

Exception:

For clients diagnosed with **high anisometropia**, MAA covers the contact lenses above when the client's refractive error difference between the two eyes is plus or minus 3.0 diopters and eyeglasses cannot reasonably correct the refractive errors.

Medical Problems	ICD-9-CM Diagnosis Code
High anisometropia	367.31

A client who qualifies for contact lenses as the primary refractive correction method must choose one style of contact lenses from those listed in #1 or #2 above for each 12-month period of coverage.

Soft Toric Contact Lenses [Refer to WAC 388-544-0400 (4)]

MAA covers soft toric contact lenses for clients with astigmatism requiring a cylinder correction of plus or minus 1.0 diopter in at least one eye. The client must have a spherical correction of plus or minus 6.0 diopters or greater in at least one eye.

Medical Problems	ICD-9-CM Diagnosis Code
Astigmatism	367.20 - 367.22

Specialty Contact Lens Designs [Refer to WAC 388-544-0400 (5)]

MAA covers specialty contact lens designs for clients who are diagnosed with one or more of the following:

Medical Problems	ICD-9-CM Diagnosis Code
Aphakia	379.31 743.35
Keratoconus	371.60-371.62 743.41
Corneal softening	371.23

Replacement Contact Lenses – Lost or Damaged

[Refer to WAC 388-544-0400 (6)(a) and (c)]

MAA covers replacement contact lenses once every 12 months for lost or damaged contact lenses. To receive payment:

- For **adults** (clients 21 years of age or older): Providers must follow the expedited prior authorization process (see Section D – *Authorization* **EPA# 627**);
- For **children** (clients 20 years of age or younger): MAA does not require prior authorization;
- For **clients with developmental disabilities** (regardless of age): MAA does not require prior authorization.

Replacement Contact Lenses – Surgery/Medication/Disease

[Refer to WAC 388-544-0400 (6)(b) and (c)]

MAA covers replacement contact lenses as often as medically necessary when all of the following apply:

- One of the following cause the vision change:
  - ✓ Eye surgery;
  - ✓ The effect(s) of prescribed medication; or
  - ✓ One or more diseases affecting vision; **and**
- The client has a stable visual condition (see Definitions section – *stable visual condition*); **and**
- The client's treatment is stabilized; **and**
- The lens correction has a 1.0 or greater diopter change in at least one eye between the sphere or cylinder correction. The previous and new refraction must be documented in the client's record.

To receive payment for replacement contacts related to surgery, medication, or disease:

- For **adults** (clients 21 years of age or older): Providers must follow the expedited prior authorization process (see Section D – *Authorization* **EPA# 621**);
- For **children** (clients 20 years of age or younger): MAA does not require prior authorization;
- For **clients with developmental disabilities** (regardless of age): MAA does not require prior authorization.

Therapeutic Contact Bandage Lenses [Refer to WAC 388-544-0400 (7)]

MAA covers therapeutic contact bandage lenses only when needed immediately after either of the following:

Medical Problems	ICD-9-CM Code or CPT Code
Eye injury	ICD-9-CM codes 871.0-871.9
Eye surgery	CPT codes 65091-67599, 68020-68399

Coverage – Ocular Prosthetics/Surgeries

When does MAA cover ocular prosthetics?

[Refer to WAC 388-544-0500]

MAA covers medically necessary ocular prosthetics when provided by any of the following enrolled/contracted providers:

- Ophthalmologists;
- Ocularists; or
- Optometrists who specialize in orthotics.

When does MAA cover cataract surgery?

[Refer to WAC 388-544-0550 (1) and (2)]

MAA covers cataract surgery when:

- The surgery is included in the scope of care for the client's medical program;
- The surgery is medically necessary; and
- The provider clearly documents the need in the client's record.

MAA considers cataract surgery to be medically necessary when the client has:

- Correctable visual acuity in the affected eye at 20/50 or worse, as measured on the Snellen test chart; or
- One or more of the following conditions:
  - ✓ Dislocated or subluxated lens;
  - ✓ Intraocular foreign body;
  - ✓ Ocular trauma;
  - ✓ Phacogenic glaucoma;
  - ✓ Phacogenic uveitis;
  - ✓ Phacoanaphylactic endopthalmitis; or
  - ✓ Increased ocular pressure in a blind person experiencing ocular pain.

When does MAA cover surgery for strabismus?
[WAC 388-544-0550 (3)]

MAA covers strabismus surgery as follows:

- For clients 17 years of age and younger, when medically necessary. The provider must clearly document the need in the client's record;

- For clients 18 years of age and older, when:

  ✓ The client has double vision; and
  ✓ The surgery is not performed for cosmetic reasons.

  To receive payment for clients 18 years of age and older, providers must use MAA's expedited prior authorization process (see MAA's *Physician-Related Services Billing Instructions*, Section I).

When does MAA cover surgery for blepharoplasty/ blepharoptosis? [WAC 388-544-0550 (4)]

MAA covers blepharoplasty or blepharoptosis surgery for noncosmetic reasons when:

- The excess upper eyelid skin impairs the vision by blocking the superior visual field; and

- The vision is blocked to within ten degrees of central fixation using a central visual field test.

Coverage – Noncovered Services

What services does MAA *not* cover?

[Refer to WAC 388-544-0475]

MAA does not cover the following:

- Executive style eyeglass lenses;
- Bifocal contact lenses;
- Daily and two week disposable contact lenses;
- Contact lenses prescribed for extended wear*, except when used as therapeutic contact bandage lenses or for aphakic clients;
- Services for cosmetic purposes only;
- Glass lenses, including those that darken when exposed to light;
- Group vision screening for eyeglasses;
- Nonglare or anti-reflective lenses;
- Orthoptics and visual training therapy;
- Progressive lenses;
- Refractive surgery of any type that changes the eye's refractive error. The intent of the refractive surgery procedure is to reduce or eliminate the need for eyeglass or contact lens corrections. (This does not include intraocular lens implantation following cataract surgery);
- Sunglasses and accessories that function as sunglasses (e.g., "clip-ons");
- Upgrades at private expense to avoid MAA's contract limitation (e.g., frames that are not available through MAA's contract or noncontract frames or lenses for which the client or other person pays the difference between MAA's payment and the total cost);

***Note regarding extended wear contact lenses:** MAA's opinion is that the prolonged use of overnight wear may increase the risk of corneal swelling and ulceration. Therefore, MAA approves their use in limited situations where they are used as a therapeutic contact bandage lens or for aphakic clients.

MAA evaluates a request for any service that is listed as noncovered in this chapter under the provisions of WAC 388-501-0160.

MAA evaluates requests for covered services that are subject to limitations or other restrictions and approves such services beyond those limitations or restrictions when medically necessary, under the standards for covered services in WAC 388-501-0165.

MAA evaluates a request for a service in a covered category that has been determined to be experimental or investigational under WAC 388-531-0550, according to the provisions of WAC 388-501-0165.

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Authorization

Prior Authorization

Prior authorization is MAA's approval for certain medical services, equipment, or supplies, before the services are provided to clients, as a precondition for provider reimbursement. **Expedited prior authorization (EPA) and limitation extensions are forms of prior authorization.**

Limitation Extensions

Limitation extensions may be requested when a provider can justify that it is medically necessary to provide more units of service than allowed in MAA's billing instructions and WAC.

> **Note:** Requests for limitation extensions must be appropriate to the client's eligibility and/or program limitations. Not all eligibility groups cover all services.
> **For example**: Eyeglasses are not covered under the Family Planning Only Program.

Requesting a Limitation Extension

There are two ways to request a limitation extension:

1) Providers may be able to follow the EPA process for certain limitation extensions by using an EPA number. These EPA numbers will be subject to post payment review as in any other authorization process. (See "What is expedited prior authorization?" page D.3.)

2) In cases where the client's situation does not meet the EPA criteria for a limitation extension but the provider still feels that additional services are medically necessary, the provider must request approval from MAA in writing.

The written request must state the following:

1. The name and PIC number of the client;
2. The provider's name, provider number and fax number;
3. Additional service(s) requested;
4. Date of last dispensing and copy of last two prescriptions;
5. The primary diagnosis code and CPT code or state assigned code; and
6. Client-specific clinical justification for additional services.

Send your written request to:

Medical Request Coordinator MAA/DMM
PO Box 45506
Olympia, WA 98504-5506
Fax: (360) 586-1471

Note: To **view and download** a Vision Care Limitation Extension form, DSHS 13-739, visit the DSHS Forms and Records Management Service web site: http://www1.dshs.wa.gov/msa/forms/eforms.html. See next page for sample of DSHS 13-739 form.

To **have a paper copy sent to you**, contact DSHS Forms and Records Management Service - Phone: (360) 664-6047, Fax: (360) 664-6186
Include in your request:

- Form number and name (Vision Care Limitation Extension, DSHS 13-739);
- Quantity you want;
- Your name;
- Your office/organization name; and
- Your complete mailing address.

Expedited Prior Authorization (EPA)

[Refer to WAC 388-544-0450]

EPA numbers are designed to eliminate the need for written authorization. MAA establishes authorization criteria and identifies these criteria with specific codes, enabling providers to create an EPA number using those codes.

To bill MAA for diagnoses, procedures and services that meet the EPA criteria on the following pages, the provider must **create a 9-digit EPA number.** The first six digits of the EPA number must be **870000**. The last 3 digits must be the code assigned to the diagnostic condition, procedure, or service that meets the EPA criteria (see page D.4 for a list of EPA codes). Enter the EPA number in field **23** on the hard copy billing form, or in the *Authorization* or *Comments* field when billing electronically.

Example: The 9-digit authorization number for an exam for an adult client who has had an exam 20 months ago but now has lost his or her glasses, would be **870000610**

870000 = first six digits of all expedited prior authorization numbers;
610 = last three digits of an EPA number indicating the service and which criteria the case meets

- MAA denies payment for vision care claims submitted without the required EPA number, or the appropriate diagnosis, procedure code, or service as indicated by the last three digits of the EPA number.
- Upon request, a provider must provide documentation to MAA showing how the client's condition met the criteria for PA or EPA.
- MAA may recoup any payment made to a provider if MAA later determines that the service was not properly authorized or did not meet the EPA criteria. Refer to WAC 388-502-0100 (1)(c).
- When a client's situation does not meet the EPA criteria for vision care, or a requested service or item exceeds the limit indicated in these billing instructions, a provider must follow the requirements of WAC 388-501-0165.
- MAA evaluates a request for any service that is listed as noncovered (see page C.16) under the provisions of WAC 388-501-0160.

See Expedited Prior Authorization Criteria Coding List on next page...

Code Criteria **Code Criteria**

Exams

Visual Exam/Refraction
(Optometrists/Ophthalmologists only)
CPT: 92014-92015

610 **Eye Exam/Refraction - Due to loss or breakage:** For adults within 2 years of last exam when no medical indication exists and **both** of the following are documented in the client's record:

1) Glasses that are broken or lost or contacts that are lost or damaged; **and**
2) Last exam was at least 18 months ago.

Note: You do not need an EPA # when billing for children or clients with developmental disabilities.

Glasses

Dispensing/Fitting Fees
CPT: 92340-92342

615 **Glasses (both frames and lenses) – Due to loss or breakage** for adults - within 2 years of last dispensing glasses may be replaced when glasses are broken or lost and **all** of the following are documented in the client's record:

1) Copy of current prescription (less than 18 months old); **and**
2) Date of last dispensing; **and**
3) Both frames and lenses are broken or lost.

Note: You do not need an EPA # when billing for children or clients with developmental disabilities.

Frames

Dispensing/Fitting Fees
CPT: 92340, 92341, 92342

618 **Replacement Frames –Due to loss or breakage:** For adults - lost or broken frames may be replaced when **all** of the following are documented in the client's record:

1) No longer covered under the manufacturer's 1 year warranty; **and**
2) Copy of current prescription demonstrating the medical necessity for prescription eye wear; (see pg. C.3) **and**
3) Documentation of broken or lost frames.

Note: You do not need an EPA # when billing for children or clients with developmental disabilities.

619 **Durable Frames** for adults and children - when the following is documented in the client's record:

- The client has a diagnosed medical condition that has contributed to two or more broken eyeglass frames in a 12-month period.

Code	Criteria

Frames (cont.)

620 **Flexible Frames** for adults and children - when the following is documented in the client's record:

- The client has a diagnosed medical condition that has contributed to two or more broken eyeglass frames in a 12-month period.

Eyeglass Lenses

Dispensing/Fitting Fees
CPT: 92340 - 92342

623 **Replacement eyeglass lenses – Due to loss or breakage:** For adults, lost or broken lenses may be replaced when **all** of the following are documented in the client's record:

1) Copy of current prescription (prescription is less than 18 months old); **and**
2) Date of last dispensing (if known); **and**
3) Documentation of lens damage or loss.

Note: You do not need an EPA # when billing for children or clients with developmental disabilities.

Eyeglass Lenses (cont.)

622 **Replacement eyeglass lenses - Due to eye surgery/effects of prescribed medication/diseases affecting vision:** For adults and children - within 2 years of last dispensing when:

1) The client has a stable visual condition (see Definition section); **and**
2) The client's treatment is stabilized; **and**
3) The lens correction must have a 1.0 or greater diopter change between the sphere or cylinder correction in at least one eye; **and**
4) The previous and new refraction must be documented in the client record.

624 **Replacement eyeglass lenses – Due to headaches/blurred vision/difficulty with school or work:** For adults and children - within 2 years of last dispensing, for refractive changes (provider error is the responsibility of the provider to warranty their work and replace the lens at no charge) when **all** of the following are documented in the client's record:

1) The client has symptoms e.g., headaches, blurred vision, difficulty with school or work; **and**
2) Copy of current prescription (prescription is less than 18 months old for adults); **and**
3) Date of last dispensing, if known; **and**
4) Absence of a medical condition that is known to cause temporary visual acuity changes (e.g. diabetes, pregnancy); **and**
5) A refractive change of at least .75 diopter or greater between the sphere or cylinder correction in at least one eye.

Code	Criteria	Code	Criteria

Eyeglass Lenses (cont.)

625 **High index eyeglass lenses** for adults and children when **one** of the following is documented in the client's record:

1) A spherical refractive correction of +\- 8.0 diopters or greater; **or**
2) A cylinder correction of +\- 3.0 diopters or greater.

Contact Lenses

Dispensing/Fitting Fees
CPT: 92070, 92310-92317

627 **Replacement Contact Lenses – Due to loss or breakage**: For adults - once every 12 months when contact lenses are lost or damaged **and** the prescription is less than 18 months old.

Note: You do not need an EPA # when billing for children or clients with developmental disabilities.

Contact Lenses (cont.)

621 **Replacement Contact Lenses – Due to eye surgery/effects of prescribed medication/diseases affecting vision:** For adults - within 1 year of last dispensing when:

1) The client has a stable visual condition (see Definition section); **and**
2) The client's treatment is stabilized; **and**
3) The lens correction has a 1.0 or greater diopter change in at least one eye between the sphere or cylinder correction; **and**
4) The previous and new refraction are documented in the client record.

Note: You do not need an EPA # when billing for children or clients with developmental disabilities.

Note: See MAA's *Physician-Related Services Billing Instructions* section I for EPA numbers for blepharoplasties and strabismus surgery.

Where and How Do I Order?

Who is MAA's eyeglass contractor?

MAA's eyeglass contractor is Airway Optical, which is part of the Washington State Department of Correctional Industries.

Providers must obtain all hardware through Airway Optical. MAA does **not** pay any other optical manufacturer or provider for frames, lens, or contact lenses.
[Refer to WAC 388-544-0150]

If a client owns serviceable frames that meet MAA's size and style requirements, MAA will pay for a fitting fee.

Send or fax completed prescriptions and/or purchase orders for sample kits, eyeglass frames, eyeglass lenses, and contact lenses to:

Airway Optical

11919 West Sprague Avenue
PO Box 1959
Airway Heights, WA 99001-1959
Customer Service: (888)-606-7788 (toll free)
Fax: (888) 606-7789 (toll free)

General Ordering Information

- **Call Airway Optical for prescription order forms,** toll-free numbers – Phone: (888) 606-7788 or Fax: (888) 606-7789.

- All prescriptions must be legible. Include the provider's number, name, and return address. **For timely processing, all information on the prescription must be completed.**

- Airway Optical does not accept Medical ID cards that have been altered in any way other than the removal or blacking out of personal information (e.g., SSN, address, client phone number). Hardware order date must fall within the eligibility dates on the Medical ID card. **Example:** If the provider orders contacts for a client on September 26th, the attached Medical ID card must be for the month of September.

- Airway Optical ships the eyeglasses to the provider.

- Mail eyeglass orders, along with a copy of the client's Medical ID card, to the contractor. You may also fax orders and DSHS Medical ID cards. Airway Optical must receive a legible fax of the Medical ID card. Keep a copy of the order on file, along with the verification of the fax order.

- Include the appropriate ICD-9-CM diagnosis code (and EPA number, if applicable) on all order forms for eyeglasses and contact lenses. If this information is not included on the form, the contractor is required to reject and return the order.

- Airway Optical rejects and returns orders for clients for whom MAA has already purchased a pair of lenses and/or complete frames or contact lenses within the applicable benefit period (12 or 24 months, as appropriate).

- DSHS requires Airway Optical to process prescriptions within 10 working days, including shipping and handling time, after receipt of a **properly** completed order. MAA allows up to 20 working days for completing orders for specialty eyeglass lenses or contact lenses. Airway Optical must notify the provider when a prescription cannot be processed within either of these specified delivery timeframes.

- To obtain general information, or to inquire about overdue prescriptions, call Airway Optical at (888) 606-7788 or fax the request to Airway at (888) 606-7789. Please have the medical record number ready when you call. **Airway Optical's phone number is for provider use only**. Airway Optical cannot check a client's eligibility. For questions regarding client eligibility, call MAA at (800) 562-6188.

- Airway Optical bills MAA directly for all hardware for MAA clients.

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Fee Schedule

Due to its licensing agreement with the American Medical Associations, MAA publishes only the official, brief CPT procedure code descriptions. To view the entire description, please refer to your current CPT book.

Payable to Ophthalmologists, Optometrists and Opticians

Procedure Code/ Modifier	Description	Maximum Allowable Effective 7/1/05 NFS	FS
Contact Lens Services			
92070	Fitting of contact lens for treatment of disease (Does not include any follow-up days)	41.11	23.62
Spectacle Fitting fees, monofocal			
92340	Fitting of spectacles	24.75	24.75
92352	Special spectacles fitting	24.30	24.30
Spectacle Fitting fees, bifocal			
92341	Fitting of spectacles	27.93	27.93
Spectacle Fitting fees, multifocal			
92342	Fitting of spectacles	29.75	29.75
92353	Special spectacles fitting	28.61	28.61
Other			
92354	Special spectacles fitting	206.43	206.43
92370	Repair & adjust spectacles	20.44	10.67
92371	Repair & adjust spectacles	14.76	14.76
92390	Supply of spectacles *(Use for materials for eyeglass repair only.)*	15.17	15.17
92499	Eye service or procedure	BR	BR

Fitting fees are *not* covered by Medicare and may be billed directly to the MAA without attaching a Medicare denial.

Payable to Ophthalmologists and Optometrists Only

BR = By Report; # = Not covered
NFS = Non-facility Setting; FS = Facility Setting

Procedure Code/ Modifier	Description	Maximum Allowable Effective 7/1/05 NFS	FS
General Ophthalmological Services			
92002	Eye exam, new patient	42.92	28.16
92004	Eye exam, new patient	78.12	54.50
92012	Eye exam established pat	39.52	22.26
92014	Eye exam & treatment	58.14	36.56
Special Ophthalmological Services			
92015	Refraction	43.15	12.26
92018	New eye exam & treatment	82.89	82.89
92019	Eye exam & treatment	43.38	43.38
92020	Special eye evaluation	16.58	12.26
92060	Special eye evaluation	33.16	33.16
92060 – TC	Special eye evaluation	10.45	10.45
92060 – 26	Special eye evaluation	22.71	22.71
92065	Orthoptic/pleoptic training	#	#
92065 – TC	Orthoptic/pleoptic training	#	#
92065 – 26	Orthoptic/pleoptic training	#	#
92081	Visual field examination(s)	30.20	30.20
92081 - TC	Visual field examination(s)	18.40	18.40
92081 - 26	Visual field examination(s)	11.81	11.81
92082	Visual field examination(s)	38.83	38.83
92082 – TC	Visual field examination(s)	24.30	24.30
92082 – 26	Visual field examination(s)	14.53	14.53
92083	Visual field examination(s)	44.74	44.74
92083 – TC	Visual field examination(s)	28.16	28.16
92083 – 26	Visual field examination(s)	16.58	16.58
92100	Serial tonometry exam(s)	52.46	29.75
92120	Tonography & eye evaluation	43.60	26.12

BR = By Report; # = Not covered
NFS = Non-facility Setting; FS = Facility Setting

Procedure Code/ Modifier	Description	Maximum Allowable Effective 7/1/05	
		NFS	FS
92130	Water provocation tonography	48.37	27.48
92135	Opthalmic dx imaging	26.57	26.57
92135 – TC	Opthalmic dx imaging	14.99	14.99
92135 – 26	Opthalmic dx imaging	11.58	11.58
92136	Ophthalmic biometry	52.01	52.01
92136 – TC	Ophthalmic biometry	33.84	33.84
92136 – 26	Ophthalmic biometry	17.94	17.94
92140	Glaucoma provocative tests	34.52	16.35
Ophthalmoscopy			
92225	Special eye exam, initial	13.85	12.49
92226	Special eye exam, subsequent	12.49	10.90
92230	Eye exam with photos	49.28	18.62
92235	Eye exam with photos	80.17	80.17
92235 – TC	Eye exam with photos	52.91	52.91
92235 - 26	Eye exam with photos	27.48	27.48
92240	Icg angiography	167.60	167.60
92240 – TC	Icg angiography	130.36	130.36
92240 – 26	Icg angiography	37.24	37.24
92250	Eye exam with photos	45.65	45.65
92250 – TC	Eye exam with photos	31.11	31.11
92250 – 26	Eye exam with photos	14.53	14.53
92260	Ophthalmoscopy/dynamometry	10.67	6.81
Other Specialized Services			
92265	Eye muscle evaluation	54.05	54.05
92265 – TC	Eye muscle evaluation	28.39	28.39
92265 – 26	Eye muscle evaluation	25.66	25.66
92270	Electro-oculography	54.73	54.73

BR = By Report; # = Not covered
NFS = Non-facility Setting; FS = Facility Setting

Procedure Code/ Modifier	Description	Maximum Allowable Effective 7/1/05 NFS	FS
92270 – TC	Electro-oculography	28.16	28.16
92270 – 26	Electro-oculography	26.57	26.57
92275	Electroretinography	68.81	68.81
92275 – TC	Electroretinography	35.20	35.20
92275-26	Electroretinography	33.38	33.38
92283	Color vision examination	23.62	23.62
92283 – TC	Color vision examination	17.94	17.94
92283 – 26	Color vision examination	5.68	5.68
92284	Dark adaptation eye exam	49.28	49.28
92284 – TC	Dark adaptation eye exam	41.79	41.79
92284 – 26	Dark adaptation eye exam	7.49	7.49
92285	Eye photography	27.71	27.71
92285 – TC	Eye photography	20.89	20.89
92285 – 26	Eye photography	6.81	6.81
92286	Internal eye photography	86.30	86.30
92286 – TC	Internal eye photography	64.04	64.04
92286 – 26	Internal eye photography	22.03	22.03
92287	Internal eye photography	73.81	25.89
Contact Lens Services			
92310	Contact lens fitting	53.37	37.70
92311	Contact lens fitting	50.42	33.16
92312	Contact lens fitting	54.28	40.88
92313	Contact lens fitting	45.87	27.93

Payable to Ophthalmologists and Optometrists Only

HCPCS Code	Description	Maximum Allowable Effective 7/1/05 All Settings

BR = By Report; # = Not covered
NFS = Non-facility Setting; FS = Facility Setting

Ocular Prosthesis		
V2623	Prosthetic, eye, plastic, custom	862.80
V2624	Polishing/resurfacing of ocular prosthesis	65.09
V2625	Enlargement of ocular prosthesis	395.77
V2626	Reduction of ocular prosthesis	213.33
V2627	Scleral cover shell	1377.82
V2628	Fabrication and fitting of ocular conformer	325.33
V2630	Anterior chamber intraocular lens	342.42
V2631	Iris, supported intraocular lens	342.42
V2632	Posterior chamber intraocular lens	342.42

Payable to Opticians Only

Procedure Code/ Modifier	Description	Maximum Allowable Effective 7/1/05 NFS	FS
Contact Lens Services			
92314	Prescription of contact lens	37.70	22.03
92315	Prescription of contact lens	29.98	14.08
92316	Prescription of contact lens	36.79	22.48
92317	Prescription of contact lens	32.25	13.85
Miscellaneous Vision Services			
V2799 - TT	Miscellaneous vision service *Use for operating costs in nursing homes. (Allowed once per visit, per facility, regardless of how many clients are seen, when eyeglass fitting or eligible repair services are performed.)*	17.01	17.01

BR = By Report; # = Not covered
NFS = Non-facility Setting; FS = Facility Setting

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General Billing

Special Instructions for Billing

Special Ophthalmological Services - Bilateral Indicator: MAA considers special ophthalmological services to be bilateral if they are routinely provided on both eyes. For MAA purposes, this includes CPT code 92015, determination of refractive state. Do not use bilateral modifier 50 or modifiers LT and RT for these services since payment is based on a bilateral procedure.

Billing for Ocular Prosthetics: Refer to MAA's *Physician-Related Services Billing Instructions* for a complete list of CPT codes and maximum allowable fees (visit: http://maa.dshs.wa.gov and select *Billing Instructions/Numbered Memoranda*). For HCPCS procedure codes, see page F.5 of the Vision Fee Schedule.

Reporting Diagnoses: MAA requires a diagnosis for a medical condition. The diagnosis assigned to a procedure is the first-level justification for that procedure.

Note: Use V72.0 (Examination of eyes and vision) only for eye exams in which no problems were found.

E & M Procedures: Use evaluation and management (E&M) codes for eye examinations for a medical problem, **not** for the prescription of eyeglasses or contact lenses. ICD-9-CM diagnosis codes 367.0-367.9 and "V" codes are **not** appropriate when billing E&M services.

MAA does not pay for:

- ✓ Evaluation and Management (E&M) codes and an eye exam on the same day;
- ✓ Nursing home visits and an eye exam on the same day; or
- ✓ Any services with prescriptions over 2 years old;

Modifier 55 for Optometrists: When billing follow-up for surgery procedures, use the surgery code and modifier 55 to bill MAA.

Billing: Since payment for the surgical procedure codes with modifier 55 is a one-time payment covering the postoperative period, MAA denies any claims submitted for related services provided during that period. You must bill any other specific problems treated during that period using modifier 25.

Payment: The amount allowed for postoperative management will be based on the Physician-Related Services Fee Schedule. (Visit the MAA web site at http://maa.dshs.wa.gov and select the *Billing Instructions/Numbered Memoranda* and the *Fee Schedules* link or call (800) 562-6188.)

What is the time limit for billing? [Refer to WAC 388-502-0150]

MAA has two timeliness standards for: 1) initial claims; and 2) resubmitted claims.

- **Initial Claims**

  ✓ MAA requires providers to obtain an ICN for an **initial claim** within 365 days from any of the following:

  - The date the provider furnishes the service to the eligible client;
  - The date a final fair hearing decision is entered that impacts the particular claim;
  - The date a court orders MAA to cover the services; or
  - The date DSHS certifies a client eligible under delayed[1] certification criteria.

  ✓ MAA may grant exceptions to the 365 day time limit for **initial claims** when billing delays are caused by either of the following:

  - DSHS certification of a client for a retroactive[2] period; or
  - The provider proves to MAA's satisfaction that there are other extenuating circumstances.

☞ **Note:** Include any necessary documentation with the billing.

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[1] **Delayed Certification:** According to WAC 3880-00-0005 delayed certification means department approval of a person's eligibility for a covered service made after the established application processing time limits. If, due to delayed certification, the client becomes eligible for a covered services that has already been provided, **the provider must not bill**, demand, collect, or accept payment from the client or anyone on the client's behalf for the service; and **must promptly refund** the total payment received from the client or anyone acting on the client's behalf and then bill MAA for the service.

Eligibility Established After Date of Service but Within the Same Month – If the client becomes eligible for a covered service that has already been provided because the client applied to the department for medical services later in the same month the service was provided (and is made eligible from the first day of that month), **the provider must not bill**, demand, collect, or accept payment from the client or anyone acting on the client's behalf for the service; and **must promptly refund** the total payment received from the client or anyone acting on the client's behalf and then bill MAA for the service.

[2] **Retroactive Certification:** According to WAC 388-8500-0005, retroactive period means the 3 calendar months before the month of application (month in which client applied). If, due to retroactive certification, the client becomes eligible for a covered service that has already been provided, **the provider must not bill**, demand, collect, or accept payment from the client or anyone acting on the client's behalf for any unpaid charges for the service; **and may refund** any payment already received from the client or anyone acting on the client's behalf, and after refunding the payment, the provider may bill MAA for the service.

- **Resubmitted Claims**

  ✓ Providers may **resubmit, modify, or adjust** any timely initial claim, **except** prescription drug claims, for a period of 36 months from the date of service. Prescription drug claims must be resubmitted, modified, or adjusted within 15 months from the date of service.

> ☞ **Note:** MAA does not accept any claim for resubmission, modification, or adjustment after the allotted time period listed above.

- The time periods do not apply to overpayments that the provider must refund to DSHS. After the allotted time periods, a provider may not refund overpayments to MAA by claim adjustment. The provider must refund overpayments to MAA by a negotiable financial instrument, such as a bank check.

- The provider, or any agent of the provider, must not bill a client or a client's estate when:

  ✓ The provider fails to meet these listed requirements; and
  ✓ MAA does not pay the claim.

What fee should I bill MAA for eligible clients?

Bill MAA your usual and customary fee.

How do I bill for services provided to Primary Care Case Management (PCCM) clients?

For the client who has chosen to obtain care with a Primary Care Case Manager (PCCM), the identifier in the HMO column will be "PCCM." These clients must obtain their services through the PCCM. The PCCM is responsible for coordination of care just like the primary care provider in a managed care plan setting. **Please refer to the client's Medical ID card for the PCCM.**

When billing for services provided to PCCM clients:

- Enter the referring physician or PCCM name in field **17** on the HCFA-1500 claim form; and

- Enter the seven-digit, MAA-assigned identification number of the PCCM who referred the client for the service(s). If the client is enrolled with a PCCM and the PCCM referral number is not in field **17a** when you bill MAA, the claim will be denied.

What records must I keep? [Refer to WAC 388-502-0020 (1)(a) through (c)]

Enrolled providers must:

- Keep legible, accurate, and complete charts and records to justify the services provided to each client, including, but not limited to:

  - ✓ Client's name and date of birth;
  - ✓ Dates of service(s);
  - ✓ Name and title of person performing the service, if other than the billing practitioner;
  - ✓ Chief complaint or reason for each visit;
  - ✓ Pertinent medical history;
  - ✓ Pertinent findings on examination;
  - ✓ Medications, equipment, and/or supplies prescribed or provided;
  - ✓ Description of treatment (when applicable);
  - ✓ Recommendations for additional treatments, procedures, or consultations;
  - ✓ X-rays, tests, and results;
  - ✓ Plan of treatment and/or care, and outcome; and
  - ✓ Specific claims and payments received for services.

- Assure charts are authenticated by the person who gave the order, provided the care, or performed the observation, examination, assessment, treatment or other service to which the entry pertains.

- Make charts and records available to DSHS, its contractors, and the US Department of Health and Human Services, upon their request, **for at least six years from the date of service** or more if required by federal or state law or regulation.

How do I bill for clients who are eligible for Medicare and Medical Assistance?

If a client is eligible for both Medicare and Medical Assistance (otherwise known as "dual-eligible"), **you must first submit a claim to Medicare and accept assignment within Medicare's time limitations**. MAA may make an additional payment after Medicare reimburses you.

- If Medicare pays the claim, the provider must bill MAA within six months of the date Medicare processes the claims.

- If Medicare denies payment of the claim, MAA requires the provider to meet MAA's initial 365-day requirement for initial claims (see page G.2).

Information Specific to Vision Care

- Medicare will furnish one pair of contact lenses or eyeglasses following each cataract surgery for aphakic clients. If these clients are eligible for both Medicare and Medical Assistance, **MAA may cover services and eye wear which are not covered by Medicare.**

- Bill Medicare first for eye examinations for dual-eligible clients.

- Bill MAA for refractions and fitting fees for dual-eligible clients. Medicare does not cover these services.

If Medicare denies a service as noncovered, or the client is not eligible for Medicare Part B, submit the claim to MAA on the HCFA-1500 claim form with the Medicare denial (EOMB) attached.

MAA must receive claims for dual-eligible clients MAA within six (6) months of the Medicare EOMB statement date. The 365-day billing period does not apply in this case.

Medicare Part B

Benefits covered under Part B include: **Physician, outpatient hospital services, home health, durable medical equipment, and other medical services and supplies** not covered under Part A.

When the words *"This information is being sent to either a private insurer or Medicaid fiscal agent,"* appear on your Medicare remittance notice, it means that your claim has been forwarded to MAA or a private insurer for deductible and/or coinsurance processing.

If you have received a payment or denial from Medicare, but it does not appear on your MAA Remittance and Status Report (RA) within 45 days from Medicare's statement date, you should bill MAA directly.

- If Medicare has made payment, and there is a balance due from MAA, you must submit a HCFA-1500 claim form (with the "XO" indicator in field **19**). Bill only those lines Medicare paid. Do not submit paid lines with denied lines. This could cause a delay in payment.

- If Medicare denies services, but MAA covers them, you must bill on a HCFA-1500 claim form (without the "XO" indicator in field **19**). Bill only those lines Medicare denied. Do not submit denied lines with paid lines. This could cause a delay in payment.

- If Medicare denies a service that requires prior authorization by MAA, MAA will waive the prior authorization requirement. Approval or denial of your request will be based upon medical necessity.

Note:

✓ Medicare/Medical Assistance billing claims must be received by MAA within 6 months of the Medicare EOMB paid date.

✓ A Medicare Remittance Notice or EOMB must be attached to each claim.

Payment Methodology – Part B

- MMIS compares MAA's allowed amount to Medicare's allowed amount and selects the lesser of the two. (If there is no MAA allowed amount, we use Medicare's allowed amount.)

- Medicare's payment is deducted from the amount selected above.

- If there is *no* balance due, the claim is denied because Medicare's payment exceeds MAA's allowable.

- If there *is* a balance due, payment is made towards the deductible and/or coinsurance up to MAA's maximum allowable.

MAA cannot make direct payments to clients to cover the deductible and/or coinsurance amount of Part B Medicare. MAA *can* pay these costs to the provider on behalf of the client when:

1) The provider **accepts** assignment; and

2) The total combined reimbursement to the provider from Medicare and Medicaid does not exceed Medicare or Medicaid's allowed amount, whichever is less.

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How to Complete the HCFA-1500 Claim Form

Note: MAA encourages providers to make use of electronic billing options. For information about electronic billing, refer to the *Important Contacts* section

The HCFA-1500 (U2) (12-90) (Health Insurance Claim Form) is a universal claim form used by many agencies nationwide; a number of the fields on the form do not apply when billing MAA. Some field titles may not reflect their usage for this claim type. The numbered boxes on the claim form are referred to as fields.

Failure to comply with the following instructions may result in the claim being denied or suspended. Either of these actions will extend the time period between claims submission and final adjudication.

Guidelines/Instructions for Paper Claim Submission:

- **Use only the original preprinted red and white HCFA-1500 claim forms** (version 12/90 or later, preferably on 20# paper). This form is designed specifically for optical character recognition (OCR) systems. The scanner **cannot read** black and white (copied, carbon, or laser-printer generated) HCFA-1500 claim forms.

- **Do not use red ink pens, highlighters, "post-it notes," stickers, correction fluid or tape** anywhere on the claim form or backup documentation. The red ink and/or highlighter will not be picked up in the scanning process. Vital data will not be recognized. Do not write or use stamps or stickers that say, "REBILL," "TRACER," or "SECOND SUBMISSION" or similar statements on claim form.

- **Use standard typewritten fonts** that are 10 CPI (Characters Per Inch).
  Do not mix character fonts on the same claim form. Do not use italics or script.

- **Use upper case** (capital letters) for all alpha characters.

- **Use black** printer ribbon, ink-jet, or laser printer cartridges. **Make sure ink is not faded or too light!**

- **Ensure all the claim information is entirely contained within the proper field** on the claim form and on the same horizontal plane. Misaligned data will delay processing and may even be missed.

- **Place only six detail lines on each claim form**. MAA does not accept "continued" claim forms. If more than six detail lines are needed, use additional claim forms.

- **Show the total amount for each claim form separately**. Do not indicate the entire total (for all claims) on the last claim form; **total each claim form**.

Field	Description

1a. **Insured's ID No.**: Required. Enter the Patient Identification Code (PIC) - an alphanumeric code assigned to each MAA client - exactly as shown on the Medical ID card consisting of the client's:

- First and middle initials (a dash [-] *must* be used if the middle initial is not available).
- Six-digit birthdate, consisting of *numerals only* (MMDDYY).
- First five letters of the last name. If there are fewer than five letters in the last name, leave spaces for the remainder before adding the tiebreaker.
- An alpha or numeric character (tiebreaker).

For example:

- ➢ Mary C. Johnson's PIC looks like this: MC010667JOHNSB.
- ➢ John Lee's PIC needs two spaces to make up the last name, does not have a middle initial and looks like this: J-100257LEE B

2. **Patient's Name**: Required. Enter the last name, first name, and middle initial of the MAA client (the receiver of the services for which you are billing).

3. **Patient's Birthdate**: Required. Enter the birthdate of the MAA client.

Field	Description

4. **Insured's Name (Last Name, First Name, Middle Initial)**: When applicable. If the client has health insurance through employment or another source (e.g., private insurance, Federal Health Insurance Benefits, CHAMPUS, or CHAMPVA), list the name of the insured here. Enter the name of the insured except when the insured and the client are the same - then the word *Same* may be entered.

5. **Patient's Address**: Required. Enter the address of the MAA client who has received the services you are billing for (the person whose name is in field **2.**)

9. **Other Insured's Name**: Secondary insurance. When applicable, enter the last name, first name, and middle initial of the insured. If the client has insurance secondary to the insurance listed in field **11**, enter it here.

9a. Enter the other insured's policy or group number *and* his/her SSN.

9b. Enter the other insured's date of birth.

9c. Enter the other insured's employer's name or school name.

9d. Enter the insurance plan name or program name (e.g., the insured's health maintenance organization, private supplementary insurance).

Field	Description

Please note: DSHS, Medicaid, Welfare, Provider Services, Healthy Options, First Steps, and Medicare, etc., are **inappropriate** entries for this field.

10. **Is Patient's Condition Related To**: Required. Check *yes* or *no* to indicate whether employment, auto accident or other accident involvement applies to one or more of the services described in field **24**. ***Indicate the name of the coverage source in field*** **10d** (L&I, name of insurance company, etc.).

11. **Insured's Policy Group or FECA (Federal Employees Compensation Act) Number**: Primary insurance. When applicable, this information applies to the insured person listed in field **4**. Enter the insured's policy and/or group number and his/her social security number. The data in this field will indicate that the client has other insurance coverage and Medicaid pays as payer of last resort.

    11a. Insured's Date of Birth: Primary insurance. When applicable, enter the insured's birthdate, if different from field **3**.

    11b. Employer's Name or School Name: Primary insurance. When applicable, enter the insured's employer's name or school name.

Field	Description

    11c. Insurance Plan Name or Program Name: Primary insurance. When applicable, show the insurance plan or program name to identify the primary insurance involved. *(***Note***: This may or may not be associated with a group plan.)*

    11d. Is There Another Health Benefit Plan? Required if the client has secondary insurance. Indicate *yes* or *no*. If yes, you should have completed fields **9a.-d**. If the client has insurance, and even if you know the insurance will not cover the service you are billing, you must check *yes*. If **11d.** is left blank, the claim may be processed and denied in error.

17. **Name of Referring Physician or Other Source**: When applicable, enter the referring physician or Primary Care Case Manager name.

    17a. ID Number of Referring Physician: When applicable, 1) enter the 7-digit MAA-assigned primary physician number; or 2) when the PCCM referred the service, enter his/her 7-digit identification number here. If the client is enrolled in a PCCM plan and the PCCM referral number is not in this field when you bill MAA, the claim will be denied.

Field	Description

19. **Reserved For Local Use:** When applicable, enter indicator ***B*** to indicate "Baby on Parent's PIC." Please specify twin A or B, triplet A, B, or C here.

21. **Diagnosis or Nature of Illness or Injury**: When applicable, enter the appropriate diagnosis code(s) in areas 1, 2, 3, and 4.

22. **Medicaid Resubmission**: When applicable. If this billing is being submitted beyond the 365-day billing time limit, enter the ICN that verifies that your claim was originally submitted within the time limit. (The ICN number is the *claim number* listed on the *Remittance and Status Report*.)

23. **Prior Authorization Number**: When applicable. If the service or hardware you are billing for requires prior authorization, enter the 9-digit number assigned to you. (See field **24K** for EPA).

24. **Enter only one (1) procedure code per detail line (fields *24A - 24K*). If you need to bill more than 6 lines per claim, please use an additional HCFA-1500 claim form.**

24A. **Date(s) of Service**: Required. Enter the "from" and "to" dates using all six digits for each date. Enter the month, day, and year of service numerically (e.g., June 04, 2005 = 060405).

Field	Description

24B. **Place of Service**: Required. Enter the appropriate code as follows:

Code Number	To Be Used For
11	Office
31	Skilled Nursing Facility
32	Nursing Facility

24D. **Procedures, Services or Supplies CPT/HCPCS**: Required. Enter the appropriate procedure code for the service(s) being billed.

24E. **Diagnosis Code**: Required. Enter the ICD-9-CM diagnosis code related to the procedure or service being billed (for each item listed in **24D**). A diagnosis code is required for each service or line billed. Enter the code exactly as shown in ICD-9-CM current volume.

24F. **$ Charges**: Required. Enter your usual and customary charge for the service performed. If more than one unit is being billed, the charge shown must be for the total of the units billed. Do not include dollar signs or decimals in this field. Do not add sales tax. Sales tax is automatically calculated by the system and included with your remittance amount.

24G. **Days or Units**: Required. Enter the total number of days or units (up to 999) for each line. These figures must be whole units.

Field	Description

24K. **Reserved for local use**: When applicable. Enter the required 9-digit EPA number only on the detail line to which the EPA number specifically applies.

25. **Federal Tax ID Number: Leave this field blank.**

Your Patient's Account No.: Not required but can be entered for your internal purposes. Enter an alphanumeric ID number, i.e., a medical record number or patient account number. Do not enter spaces or the following characters in this field:

* (asterisk)
~ (tilde)
: (colon)

This number will be printed on your *Remittance and Status Report* under the heading *Patient Account Number.*

28. **Total Charge**: Required. Enter the sum of your charges. Do not use dollar signs or decimals in this field.

29. **Amount Paid**: If you receive an insurance payment or client-paid amount, show the amount here, and attach a copy of the insurance EOB. If payment is received from source(s) other than insurance, specify the source in field **10d**. Do not use dollar signs or decimals in this field or put Medicare payment here.

30. **Balance Due**: Required. Enter balance due. Enter total charges minus any amount(s) in field **29**. Do not use dollar signs or decimals in this field.

Field	Description

33. **Physician's, Supplier's Billing Name, Address, Zip Code And Phone #**: Required. Put the *Name, Address* on all claim forms.

PIN #: This is the seven-digit number assigned to you by MAA for:

A. An individual practitioner (solo practice); **or**
B. An identification number for individuals only when they are part of a group practice (see below).

Grp #: This is the seven-digit number assigned by MAA to a provider group that identifies the entity (e.g., clinic, lab, hospital emergency room, etc.). When a valid group number is entered in this field, payment will be made under this number. **Note: When billing a Grp #, you must include a PIN #.**

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